ZdravReform/ЗдравРеформ

ZdravReform Program Strategies

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The purpose of this paper is to describe ZdravReform program strategies. ZdravReform can be defined in terms of concept, program strategies and program activities. The conceptual foundation of the health reform model as well as detailed technical and program activities are described in other papers and reports. Six major program strategies are described below – Demonstrations; Conceptual Health Reform Model; Operational Orientation; Relationship to Economic Restructuring and Democratic Transition; Collaboration with the World Bank, other Donors and other USAID Projects; and Regional Program.

Demonstrations

The demonstration program strategy was established contractually at the beginning of the ZdravReform Program. Before discussing specifics of this strategy, it is important to define both the major parameters of a demonstration and a successful demonstration. A health reform demonstration cannot be implemented in a geographic area smaller than an oblast. This is because one of the core elements of the health reform model involves changes in health financing/provider payment systems and these fund flow changes need to occur at the oblast level. A successful demonstration is one that not only reforms elements of the health sector within a certain geographic area, but also facilitates extension or roll-out of the model to either the national level or other regions within the country.

The nature and success of the demonstration model varies by country. It can be hypothesized that the variable most highly correlated with demonstration success across the Central Asian countries is the level of decentralization of authority from the national to the regional level. This factor as well as other contributors is used to frame the following discussion of demonstrations across countries.

In Kyrgyzstan, the demonstration in Issyk-kul was very successful and has driven the entire reform process throughout Kyrgyzstan. Factors which appear to have contributed to this success include relative centralization of authority, Kyrgyzstan's awareness of its small size, the desire of Kyrgyzstan to maintain one system throughout the country, and the lack of other health reforms occurring before the demonstration was introduced.

Plans for the roll-out of the Issyk-kul demonstration began to be developed in collaboration with the World Bank in 1995. Although at that point, the Issyk-kul demonstration was still in its very early stages, a mechanism to accomplish the roll-out was already under development. Today, Kyrgyzstan has largely completed the conversion from a demonstration to national level reforms. While the health reforms are far from completed, the process of extending the reforms to other oblasts will be done within a national framework rather than as demonstrations.

In Kazakhstan, the situation was very different. The first demonstration in South Kazakhstan, while producing some valuable technical products, was not overly successful.

ZdravReform assessed the major reasons to be a higher level of decentralization from national to regional levels in Kazakhstan, the sheer geographic enormity and diversity of the country, and the existence of health reforms in other oblasts which diluted the focus on South Kazakhstan.

At that point, the ZdravReform Program adapted the demonstration strategy to fit the environment in Kazakhstan. Rather than investing all resources in an Intensive Demonstration Site, the program adapted a target of opportunity demonstration model termed Comprehensive Demonstration Sites (the term comprehensive served as a selection criteria to ensure that the integrated health reform model was implemented rather than just scatter-shot interventions). It introduced a rolling design and provided more flexibility to move quickly to work in oblasts desiring to implement health reforms. Offices were not established in Comprehensive Demonstration Sites, rather the implementation of reforms was managed from the Almaty Regional Office to ensure flexibility.

The adaptation of the demonstration strategy in Kazakhstan was very successful, resulting in success in Zhezkazgan and Semipalatinsk. Recently, the environment in Kazakhstan has necessitated another adjustment in the demonstration strategy. Initially, it was felt that roll-out of demonstrations should be to the national level. However, in Kazakhstan it is becoming clear that the decentralization of authority from the national to regional level requires that the roll-out be across region. This change is reflected in the current strategy of the ZdravReform Program.

Early indications are that Uzbekistan will be a combination of the demonstration strategies implemented in Kyrgyzstan and Kazakhstan. Uzbekistan is implementing an Intensive Demonstration Site in Fergana similar to the Issyk-kul demonstration in Kyrgyzstan. However, roll-out of the model will be across region rather than to the national level, similar to Kazakhstan.

In summary, overall the demonstration strategy has been successful, although over time the strategy has been adapted to suit the Central Asian environment. In order to achieve success, roll-out of the demonstration needs to be contemplated as part of the demonstration planning process.

Conceptual Health Reform Model

The program strategy aspect of a conceptual health reform model is not the contents of the model (described in the conceptual package), but why the existence of the model is important to program implementation. It is obviously important as it drives program content, but it is also important because it allows program flexibility and clarity in an uncertain environment.

The uncertainty of the Central Asian environment can not be overstated. Geographical boundaries change often, such as in the merger of oblasts or the movement of the national capital. Government structure often changes also, for example, in the merger of ministries. Political appointments change all the time -- ZdravReform has dealt with hundreds of

major counterparts over the last few years. Still, Central Asia is part of what is arguably one of the most rapid peaceful transitions in history. Certain program interventions or activities work and other program activities do not, sometimes for reasons that are not clear and vary by time and geography.

The existence of a broad conceptual model allows program flexibility to adapt to changes in the environment. For example, if the conceptual model establishes a broad overall objective such as involving the population in decisions about their health care, a number of different program activities will facilitate achievement of this objective. Population enrollment in Family Group Practices, or health promotion, or community health activities may work better at different times and in different locations.

Two major characteristics of the health reform model are comprehensiveness and integration. The model must be comprehensive in that all the different components of the health sector are included. The model must be integrated so that impact of changes in one part of the health sector are addressed and incorporated into other parts of the health sector.

The importance of this integration of health reforms for sustainability can not be overstated. If the primary care sector is restructured and strengthened but the primary care payment systems are not changed to shift resources to primary health care, the primary care restructuring will fail. If infectious diseases or reproductive health is targeted outside of the health delivery system structure, the reforms will not be successful and may produce unintended consequences.

The ZdravReform Program developed a conceptual health reform model early in the program development. Development of this model was a specific program strategy intended to establish the broad path to reform, allowing flexible operational plans and activities to determine the milestones along the road.

It should be recognized that the broad conceptual model applies to all the countries within Central Asia. All the countries started with and still largely maintain the same health sector structure. Unlike other sectors such as legal and capital markets, which are diverging rapidly across country, the health sector in the five countries of Central Asia remains basically the same.

This does not mean that operationally, plans and activities should not vary across country. It is very important that program activities are molded to the social, economic, and political environment in each country. For example, all the countries in Central Asia need to strengthen primary health care – an objective contained in the health reform model. However, Kazakhstan, Kyrgyzstan, and Uzbekistan have all developed different types of primary care practices – the program activity varies across country, but is consistent with the objective of strengthening primary health care, which does not vary across country.

In summary, a ZdravReform program strategy was to develop a conceptual health reform model to identify and solve the main problems in the health sector of all Central Asian

countries. It serves as an umbrella to focus different program activities being implemented in an uncertain environment. Program activities are developed to achieve the objectives of the health reform model and tailored to the social, political, and economic environment of each separate country.

Operational Orientation

A major program strategy of the ZdravReform Program from the beginning has been an operational orientation. What does this mean and why is it important in this environment? The assumption is that the probability of program success and sustainability increases if the program develops partnerships with counterparts to actually implement health reforms rather than provides technical assistance and training largely through reports and seminars.

This strategy was developed through an environmental assessment of both conceptual and management strengths, weaknesses, opportunities, and threats. Conceptually, many of the problems in the health sector are at the core of the health delivery and financing system. Addressing them requires dismantling and rebuilding the health system foundation. For example, national level approval of a policy and legal framework for strengthening primary health care is not effective unless it is complemented by activities targeted at building a stronger primary health care sector from the bottom-up. In addition, it is not possible to mandate changes to health financing without the information systems in place to implement the changes, or mandate changes to clinical practice without providing intense training to health professionals and changing the roles and relationships between different institutions.

For policy-makers, health professionals, and the population to buy into substantial reform in the health sector, they have to see the changes. Reforms have to be implemented and evaluated in the demonstration model first and then can be extended and incorporated into a national framework. In addition, it is difficult to establish a national legal and policy framework until after implementation has revealed the specific, detailed elements of the framework.

In addition, resistance to health reform can not be underestimated. While health sector leaders trumpeted the need for health reform, their initial perspective came more from a desire to maintain the current system and use donors to contribute to this objective, than from progressive vision. Their stake in the old system was large as demonstrated by the often heard comment “we have the perfect health system, just give us more money.” Operational implementation of health reforms producing visible change led to both change in health decision-makers opinions and support for the few progressive health reformers.

Finally, health reformers in Central Asia are better at developing ideas than implementing ideas. The management skills required to formulate and implement plans are not well developed, as the Soviet system did not put a premium on problem solving or risk-taking behavior. Establishing a step-by-step process to implement health reform involves 1) building a foundation making the evolution of reforms more inevitable; 2) increasing

sustainability; 3) creating small successes which lead to big successes; and, 4) and developing the human resources capacity to continue expanding health reforms.

One of the main advantages of the operational orientation program strategy is that it has resulted in many lessons learned and has driven the evolution of the ZdravReform Program over time. Examples of these lessons learned are described below:

1. The initial mandate for ZdravReform was to work on health delivery system restructuring and health financing. As program activities were implemented, it quickly became clear that restructuring the health delivery system and changing health financing without addressing clinical practice was impossible and not desirable. In response, ZdravReform incorporated a substantial clinical program into the health reforms, focusing on the introduction of family practice and the incorporation of infectious diseases and reproductive health.

2. The development of primary health care required strong advocates as the health sector power structure was completely dominated by hospital sector representatives. At about the same time this became obvious; it also became evident that health may be a good vehicle to push the development of civil society as people cared about health issues. So as a result of operational experience ZdravReform began to establish NGOs to facilitate the development of new primary care practices and to contribute to democratic transition.

3. While the conceptual health reform model contained population involvement in health care decisions, it was operational experience that showed the great impact of program activities in this area. The response of the population to free choice of provider and the resulting marketing and enrollment campaigns was overwhelming and led to an increased emphasis of the program in this area. It has become a mechanism to shift power from health sector authorities to the population as now the money is starting to follow the patient rather than being allocated by health authorities to health providers.

4. Initially, ZdravReform began to introduce new financial management systems independently of provider payment systems reform. It quickly became clear that while accountants and economists were intellectually interested, no change in facility operation was occurring. This operational lesson learned resulted in a change in strategy – financial management reforms were introduced in concert with new provider payment systems. When how the facilities were being paid changed, staff immediately became interested in how to develop and implement new financial management systems.

5. The importance of institutional structure, relationships, and development in Post-Soviet society was recognized through operational implementation of reforms and remains an important consideration in the development of all health reform plans and activities.

6. The ZdravReform Program developed a training philosophy, again based on operational experience. An initial phase of broader training was done at the start of the

program, and then more practical training was done throughout the initial implementation of health reforms. Following initial implementation, broader training became more valuable again, particularly seminars bringing together reformers to share experiences.

In summary, the importance of this operational orientation to the implementation of health reform in Central Asia can not be underestimated and has proven successful.

Support Economic Restructuring and Democratic Transition

While the USAID CAR Mission strategy initially shaped the connection between health reform and the strategic objectives of economic restructuring and democratic transition, the relationship between these objectives and health reform has continued to be an important aspect of the ZdravReform Program.

Concerning economic restructuring, the health sector is a large monopoly, which needs to be decentralized to create competition and allocate limited resources more efficiently. The introduction of new provider payment systems accomplishes this objective. It is a synergistic relationship as health reform contributes to economic restructuring through more market-oriented allocation of resources and economic restructuring contributes to health reform, for example through changes in the budgeting process.

There is also an important and synergistic relationship between health reform and democratic transition. The establishment and development of NGOs in the health sector facilitates the restructuring and strengthening of primary health care. The involvement of the population in decisions about their health care has become one of the cornerstones of health reform. Free choice of primary care provider through enrollment, health promotion, and community health programs are all important aspects of health reform, which also contribute to democratic transition.

In summary, developing relationships and synergies between health reform and economic restructuring and democratic transition is a successful program strategy, which the ZdravReform Program will continue to enhance.

Collaboration with the World Bank, Other Donors and USAID Projects

One of the most important and effective ZdravReform program strategies has been its collaboration with the World Bank. This collaboration has paid significant dividends for both USAID and the World Bank. USAID brings to the partnership technical assistance that Central Asian countries are reluctant to borrow for but that the World Bank thinks is vital to ensure the sustainability of their investment. The World Bank brings to the partnership commodities and political leverage that enhances the effectiveness of USAID's investment in technical assistance.

USAID leverages resources through this collaboration with the World Bank. The collaboration facilitates the roll-out of the USAID demonstrations and creates the critical mass to begin the process of institutionalizing health reform at the national level.

The ZdravReform Program has developed collaborations with many other donors in order to coordinate and enhance the implementation of health reform. ZdravReform collaborates with the British Know How Fund on restructuring the health delivery system and family practice training, WHO on health policy development and clinical protocols, the Asian Development Bank to roll-out health reforms, GTZ on health insurance and health management, and a multitude of donors and projects on reproductive health and infectious disease issues.

Finally, ZdravReform has created linkages with other USAID health projects to enhance the effectiveness of the USAID portfolio. ZdravReform is a technical assistance model with certain strengths and weaknesses. AIHA's partnership model has different strengths and weaknesses. Collaboration between the two models enhances the effectiveness of both, particularly in clinical areas. This is even truer now as AIHA has begun partnering with Medical Academies. Effective coordination and collaboration has also been established with Project HOPE and CDC in infectious diseases and with CMS and SEATS in reproductive health. The projects have all developed relationships which have enhanced the effectiveness of the portfolio. In addition, ZdravReform has worked with the RPM project on drug issues.

Regional Program

The ZdravReform Program believes that much of the success of the Central Asian health reforms is due to the existence of a regional program. As discussed in the Conceptual Health Reform Model section, the health sector problems in all five Central Asian countries are largely the same and can be addressed by the same health reform model. However, a "cookie-cutter" approach is not relevant, as it is imperative that specific program activities be adapted to the social, political, and economic environment of each country.

It is very important to note that the countries are aware that they have similar problems and look to each other for solutions. All the Central Asian countries watch the health reforms implemented in other countries closely. They learn from each other's mistakes, for example, the policy debate on the introduction of health insurance in Uzbekistan and Tajikistan has benefited from the experience of Kazakhstan and Kyrgyzstan. If one country successfully implements an intervention, the probability increases that other countries will also implement the same activity. Over the last few years, the major request from the most progressive health reformers in each country has been for more regional seminars and other activities. These regional activities allow reformers from each country to gather to share experiences and work out solutions to common problems.

It is not possible to overestimate the impact on all of Central Asia of having one country stand out as a leader in health reform. Kyrgyzstan has filled this role in Central Asia over

the last few years. All the other Central Asian countries look to Kyrgyzstan to learn from their mistakes and replicate their successes. In other words, the successful reforms in Kyrgyzstan raise the bar and open the door to similar successes in other countries.

Program implementation benefits enormously from the ability to roll-out certain products across countries. Examples of products extended after revision to adapt to the environment in another country include:

1. Clinical training methods and materials
2. Architectural drawings
3. Equipment lists
4. Rational pharmaceutical management methodologies
5. Marketing and enrollment campaigns for the population
6. Health promotion
7. Case-based hospital payment system
8. Primary care capitated rate payment system
9. Population database and information system
10. Hospital database and information system
11. Primary care practice database and information system
12. Procedure and surgery codes
13. Practice manager training methods and materials
14. Laboratory training for primary care

In general, ZdravReform's use of the term Regional Program does not refer as much to the technical nature of the health reforms implemented in each country, as the management processes which maximize available resources through economies of scale. The Regional Program approach results in economies of scale related to administrative, financial, and contractual functions.

In addition it allows flexibility in expatriate staffing, resulting in more functional expertise being available for technical assistance. For example, pharmaceutical issues are very important in health reform. It would not be possible to maintain a pharmacist in each country. However, the Regional Program concept allows ZdravReform to maintain one pharmacist who travels and works on drug-related issues in all three countries. Technical expertise contained in the Regional Program includes clinical (physicians), pharmaceutical, laboratory, public health, health delivery systems, NGO development, legal, health policy, health economic, accounting, and health management expertise. This level of expertise would be difficult to match outside of a regional program. In addition, the program has developed local staff who are capable of providing on-going technical assistance in many program areas throughout the region.

In summary, the regional program strategy is a cornerstone of the ZdravReform Program. The health sectors of the five Central Asian countries face the same problems. Health reform implementation is enhanced by sharing experiences and extending technical products across countries. Administrative economies of scale result in efficient allocation of resources and flexible staffing allows a broad range of technical expertise.